

Cardiovascular Surgeons, P.A.

EVALUATION AND MANAGEMENT HISTORY INFORMATION FORM

Date _____ Patient Name _____

Date of Birth _____ Age _____ Sex Male Female

General Practitioner/Primary Doctor

Referring Physician/Specialist

**REVIEW OF SYSTEMS - PLEASE CHECK EACH ITEM "YES" OR "NO"
AS THEY RELATE TO YOUR HEALTH**

<u>CONSTITUTIONAL</u>	Yes	No	<u>RESPIRATORY</u>	Yes	No	<u>HEMATOLOGIC</u>	Yes	No
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Gums Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>			
<u>EYES</u>	Yes	No	<u>GASTROINTESTINAL</u>	Yes	No	<u>MUSCOLOSKELETAL</u>	Yes	No
Glasses / Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Blood / Black Stools	<input type="checkbox"/>	<input type="checkbox"/>	<u>NEUROLOGICAL</u>	Yes	No
<u>EAR, NOSE, THROAT</u>	Yes	No	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<u>CARDIOVASCULAR</u>	Yes	No	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>SKIN</u>	Yes	No
<u>GENITOURINARY</u>	Yes	No	Calf Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rash / Sores	<input type="checkbox"/>	<input type="checkbox"/>
Pain Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Frequency	<input type="checkbox"/>	<input type="checkbox"/>				Burning	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>						
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>						
History of Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>						

- | | | | |
|---|--------------------------|--------------------------|----------------------------------|
| | Yes | No | (If "yes," please list details): |
| 1. Have you ever had a vein stripping? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Have you ever had chest trauma? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Have you ever had a problem with anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Have you ever had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Do you object to receiving blood products? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PAST PATIENT HISTORY - Please list below ALL Your Past Operations, Hospitalizations, Illnesses/Injuries PLEASE BE SPECIFIC AS TO REASON AND DATES	
Please list all past operations/hospitalizations with reason & date	Please list all personal illnesses/injuries and dates

PAST PATIENT HISTORY - PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR PAST PERSONAL HISTORY					
CONDITION	Yes	No	CONDITION	Yes	No
INFECTIOUS DISEASES			ENDOCRINE		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	RENAL/GENITOURINARY		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defect of Heart	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Pericarditis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL		
Previous Stent or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beats	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY			Herniated Disc	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/ONCOLOGY		
Prior Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to Inhaling Hazardous Agent	<input type="checkbox"/>	<input type="checkbox"/>	Cancer - List Type	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGIC			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>			
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

PAST PATIENT HISTORY - PLEASE COMPLETE THE FOLLOWING TABLE		
	Health Problems	If deceased, age and cause of death
Mother		
Father		
Siblings		
Grandparents:		

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS AND DOSAGES					
Med Name	Dose	Frequency (# times per day)	Med Name	Dose	Frequency (# times per day)

Are there any medications which you stopped taking in the past month? Yes No

If you answered "yes", which medications have you stopped? _____

Are you currently taking Aspirin? Yes No How often? _____

Are you allergic to any medication? Yes No List what medication(s) _____

Describe the type of allergic reaction you had to this medication _____

SOCIAL HISTORY - PATIENT PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes No

Have you ever smoked?
 If yes: # packs/day _____ # years smoked _____

Are you still smoking?
 If you have stopped smoking, when did you quit? _____

Do you drink alcohol? If yes, please list type and quantity: _____

Do you use recreational drugs? What type _____

Do you exercise? Type _____ Miles _____ Times/day/week _____

Place of Birth: _____

Marital Status: Married Single Divorced Widowed

If surgery is planned, will you have help at home to assist in your recovery? Yes No

If no, what type of assistance do you feel that you may need? _____

Current Occupation: _____ If retired, from what? _____

Have you recently traveled outside of the United States? Yes No

If you answered "yes", where did you travel to and when? _____

CARDIOVASCULAR SURGEONS, P. A.

Paul A. Thompson, M.D.
 Kevin D. Accola, M.D.
 George J. Palmer, M.D.
 Mark E. Sand, M.D.
 Jorge E. Suarez-Cavelier, M.D.
 Jeffrey N. Bott, M.D.
 Lawrence R. McBride, M.D.

Appointment _____
 Provider _____
 Patient # _____

Our Surgeons use Physician Assistants, PA-C to assist in surgery. Please call your insurance carrier to verify whether your policy covers a PA as a surgical assistant. If they cover surgical assistants, they may only allow a surgeon who is an MD to assist. If your insurance does not cover this charge, you will be responsible for payment of the assistant surgeon charges as with any other non-covered charge.

Last Name: _____ First: _____ Middle: _____
 Address: _____ Gender: _____
 _____ Marital Status: _____
 _____ Social Security #: _____
 Home Phone: _____ Date of Birth: _____
 Work Phone: _____ Your Employer: _____
 Cell Phone: _____

Alternative Contact Name: _____
 Relation: _____
 Home: _____
 Work: _____
 Cell: _____

Please provide a number other than one listed in the patient section above. Only one number is needed.

<p>Primary _____ Insurance _____ _____ Policyholders Name: _____ Policyholders Date of Birth: _____ Phone : _____</p>	<p>Secondary _____ Insurance: _____ _____ Group #: _____ Policy#: _____</p>
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<p><i>Referring Physician:</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><i>Primary Care Physician:</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><i>Family Physician:</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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MEDICAL RECORDS RELEASE AND ASSIGNMENT OF BENEFITS

I authorize Cardiovascular Surgeons, P.A. to act in my behalf when inquiring to Medicare, Social Security Administration and/or my health insurance carrier, regardless to whom benefits are assigned, for the purpose of obtaining information regarding payment of this claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize the release of medical information to/from referring physicians and suppliers and to my insurance carrier for the purpose of processing payment of insurance benefits. I am responsible for all financial obligations and should it become necessary to pursue collection of this debt, I (we) agree to pay all costs of collection including a reasonable attorney's fee. I understand and therefore, I acknowledge and accept liability of payment for these services.

Date: _____ Signature: _____